For this paragraph, "hospital" means a facility holding the provider number as an inpatient service facility.

C. To appeal a payment rate or payment change that results from Medicare adjustments of base year information, the 60-day appeal period begins on the mailing date of the notice by the Medicare program or the date the Medical Assistance payment rate determination notice is mailed, whichever is later.

D. As part of the appeals process, hospitals are allowed to seek changes that result from differences in the type of services provided or patient acuity from the base year. This is necessary because of the time lag between the base year and the rate year. These case mix appeals are calculated after the rate year has finished. However, in a few situations such as the creation of a new program, it is prospectively evident that a case mix appeal will be successful. Therefore, in these cases, an agreement is drafted mandating a case mix appeal calculation at the end of the year and estimated payments are made on an interim basis.

## SECTION 15.0 OTHER PAYMENT FACTORS

**15.01 Charge limitation.** Individual hospital payments, excluding DPA payments, established for Medical Assistance covered inpatient services in addition to third party liability for discharges occurring in a rate year will not exceed, in aggregate, the charges for Medical Assistance covered inpatient services paid for the same period of time to a hospital.

**15.02 Indian Health Service.** Medical assistance payments to facilities of the Indian Health Service and facilities operated by a tribe or tribal organization under funding authorized by title III of the Indian Self-Determination and Education Assistance Act, Public Law Number 93 -638, or by United States Code, title 25, chapter 14, subchapter II, sections 450f to 450n, are excluded from the DRG system and are paid according to the rate published by the United States assistant secretary for health under authority of United States Code, title 42, sections 248A and 248B.

**15.03 Small rural payment adjustment.**

A. Effective for admissions occurring on or after October 1, 1992, Minnesota hospitals with 100 or fewer licensed beds on March 1, 1988, and 100 or fewer Minnesota Medical Assistance annualized admissions paid by March 1, 1988 for the period of January 1, 1987 through June 30, 1987, will have payments increased by 20 percent.

B. Effective for admissions occurring on or after October 1, 1992, Minnesota hospitals with 100 or fewer licensed beds and greater than 100 but fewer than 250 Minnesota Medical

Assistance annualized admissions paid by March 1, 1988 for the period of January 1, 1987 through June 30, 1987, will have payments increased by 15 percent.

The payment adjustment does not include Medicare crossover admissions in the admissions count nor are Medicare crossover admissions eligible for the percentage increase. Minnesota hospitals located in a city of the first class are not eligible for the payment adjustment in this section. Minnesota hospitals that receive the non-seven-county metropolitan area hospital payment adjustment under Section 15.05 are also not eligible for the payment adjustment in Section 15.03.

The small rural payment adjustment is reduced by the amount of the hospital's DPA under Sections 13.01 to 13.05 and the hospital payment adjustment under Section 15.04.

**15.04 Hospital payment adjustment.** If federal financial participation is not available for all payments made under Sections 13.01 to 13.04 and payments are made under Section 13.05 or if a hospital does not meet the criteria of Section 13.01, items A or B, and the Medical Assistance inpatient utilization rate exceeds the mean in Section 13.01, item C, a payment adjustment is determined as follows:

A. Subtract the mean for Minnesota and local trade area hospitals from the hospital's Medical Assistance inpatient rate.

B. Add 1.0 to the amount in item A.

C. If the Medical Assistance inpatient utilization rate exceeds the mean plus one standard deviation in Section 13.01, item C, the payment adjustment determined in item A is multiplied by 1.1 and added to 1.0.

D. Payment adjustments under this section are reduced by the amount of any payment received under Sections 13.01 to 13.04.

Payments made under this section are not disproportionate share hospital payment adjustments under §1923 of the Social Security Act.

**15.05 Rebasing adjustment.** Payment to Minnesota and local trade area hospitals for admissions excluding Medicare crossovers, occurring on or after October 25, 1993 include a rebasing adjustment that is designed to prospectively compensate for an effective date of July 1, 1992 under the rates and rules in effect on October 25, 1993.

A. The adjustment to each hospital is calculated as the difference between payments made under this State plan and what was paid under each State plan in effect from July 1, 1992 to October 24, 1993, excluding the indigent care payment, with the following adjustments.

(1) Rates under this State plan are deflated 5.4 percent to remove the 1993 HCI. Rates are not deflated when the admissions under adjustment occurred in 1993.

(2) The core hospital increase is included when the admissions under adjustment occurred under a State plan that included it (July 1, 1993).

(3) The small rural payment adjustment is included when the admissions under adjustment occurred under a State plan that included it (October 1, 1992).

(4) The hospital payment adjustment is included when the admissions under adjustment occurred under a State plan that included it (July 1, 1993).

(5) The DPA is calculated using base year data under this State plan and the formulas under the State plan in effect for the admissions under adjustment (changed October 1, 1992).

(6) The cash flow payment adjustment under all State plans from July 1, 1992 to October 24, 1993 is deducted from the payment for admissions under adjustment.

B. Aggregate amounts owed to the hospital under item A are reduced by twenty percent. Payments for the cash flow payment adjustment are subtracted. The net difference is divided by 1.5 times the number of admissions under adjustment after mother and baby admissions are separated to derive a per admission adjustment. A hospital with an aggregate amount owed to the Department that exceeds one million dollars and has a payment reduction due to rebasing that exceeds twenty percent will have the net difference divided by 3.0 times the number of admissions under adjustment.

C. The rebasing adjustment will be added to or subtracted from each payment for admissions excluding Medicare crossovers, occurring on or after October 25, 1993 until the aggregate amount due to or owed by a hospital is fully paid.

D. The rebasing adjustment will occur over two periods.

(1) The first adjustment for admissions occurring from July 1, 1992 to December 31, 1992 and paid by August 1, 1993 begins with admissions occurring on or after October 25, 1993.

(2) The second adjustment for admissions occurring from January 1, 1993 to October 24, 1993 and paid by February 1, 1994 begins the later of February 1, 1994 or after the first adjustment is fully

paid.

**15.06 Out of state negotiation.** Out-of-area payments will be established based on a negotiated rate if a hospital shows that the automatic payment of the out-of-area hospital rate per admission is below the hospital's allowable cost of the services. A rate is not negotiated until the claim is received and allowable costs are determined. Payments, including third party liability, may not exceed the charges on a claim specific basis for inpatient hospital services that are covered by Medical Assistance.

**15.07 Psychiatric services contracts.** The Commissioner has determined that there is a need for access to additional inpatient hospital psychiatric beds for persons with serious and persistent mental illness who have been civilly committed or voluntarily hospitalized and can be treated and discharged within 45 days. In response, contracts with non-state operated hospitals to provide inpatient hospital psychiatric services to patients who will be dually committed to the non-state operated hospital and the State-operated regional treatment center, or who have agreed to hospitalization, have been established. Payment rates for these inpatient psychiatric services are negotiated and established in the contracts executed under an open bidding process between the Commissioner and the hospitals.

A. Parameters related to the acceptance of a proposal other than cost include:

(1) the quality of the utilization review plan;

(2) experience with mental health diagnoses; and

(3) the commitment process.

B. Parameters related to acceptance of a proposal on a financial and cost basis include:

(1) payor of last resort/payment in full compliance assurances;

(2) general experience operating within the Medicare/Medical Assistance programs; and

(3) financial integrity.

C. Voluntary hospitalizations are included in the contracts under the following conditions:

(1) the ~~Department and~~ county must give prior approval;

(2) the hospitalization must be an alternative to commitment;

(3) ~~the patient must have a past history of psychiatric hospitalization requiring extended inpatient psychiatric treatment~~ the attending physician indicates that the patient is in need of continued mental health inpatient treatment and that the patient is competent to consent to treatment (or has a substitute decision maker with the authority to consent to treatment); and

(4) the physician and county would seek commitment if the patient did not agree to hospitalization.

Rates are established through the bid process with negotiation based on the cost of operating the hospital's mental health unit as derived from the Medicare cost report. The cost information, for comparison to a state-operated hospital, is adjusted to take into account average acuity and length of stay differences.

**15.08 Medical education.** In addition to Medical Assistance payments included in this Attachment, Medical Assistance provides for an additional one-time payment for medical education for Federal Fiscal Year 2002 (October 1, 2001 through September 30, 2002) to the six Minnesota Medical Assistance-enrolled teaching hospitals with the highest number of Medical Assistance admissions in State Fiscal Year 1996. The Medical Assistance payment for each of these six hospitals is increased as follows:

| | | |
|---|---|---|
| One-time Dollar Amount | x | (Total State Fiscal Year 1996 Medical Assistance admissions for one of the six Minnesota Medical-Assistance enrolled teaching hospitals) ÷ (Total State Fiscal Year 1996 Medical Assistance admissions of the six Minnesota Medical Assistance-enrolled teaching hospitals with the highest number of Medical Assistance admissions in that fiscal year) |

The one-time Medical Assistance payment for Federal Fiscal Year 2002 is $27,263,047.94. In accordance with Code of Federal Regulations, title 42, section 447.253(b)(2), this payment will not exceed the Medicare upper payment and charge limits as specified in Code of Federal Regulations, title 42, section 447.272.

**15.09 Additional adjustment for Hennepin County Medical Center and Regions Hospital.** Beginning July 15, 2001, in recognition of the services provided by the two largest safety net hospitals, an additional adjustment, in total for Hennepin County Medical Center and for Regions Hospital, will be made each month ~~to~~ that is the difference between the non-State government-owned or operated hospital Medicare upper payment limit as specified in Code of Federal Regulations, title 42, section 447.272 and the non-State government-owned or operated hospital rates of this Attachment, to a maximum of:

(1) ~~Hennepin County Medical Center in the amount of~~ $2,840,000 to Hennepin County Medical Center.

(2) ~~Regions Hospital in the amount of~~ $1,420,000 to Regions Hospital.

The adjustment in item (2) is always one-half of the adjustment in item (1).

**15.10 Non-seven-county metropolitan area hospital payment adjustment.** For a Minnesota hospital located outside of the seven-county metropolitan area, effective for admissions occurring on or after July 1, 2001 for the DRGs listed below, if 90 percent of the ~~non-~~seven-county metropolitan area hospital payment is greater than the hospital's payment, exclusive of Sections 13.01 to 13.05 and 15.04, then payment is made at 90 percent of the ~~non-~~seven-county metropolitan area hospital payment, inclusive of the ~~non-seven-county metropolitan area~~ hospital's adjustment under Sections 13.01 to 13.05 and 15.04. ~~This section is contingent upon approval of State plan amendment TN 01-17.~~

The seven-county metropolitan area hospital payment is adjusted so that payments are in the same proportion as the ratio of the actual payment to the maximum allowable specified in Section 15.09. Therefore, the payment to non-seven-county metropolitan area hospitals changes each year. However, in accordance with Code of Federal Regulations, title 42, section 447.253(b)(2), this payment adjustment will not exceed the Medicare upper payment limit as specified in Code of Federal Regulations, title 42, section 447.272.

| | | |
|---|---|---|
| (1) | cesarean section with complicating diagnosis | 370 |
| (2) | cesarean section without complicating diagnosis | 371 |
| (3) | vaginal delivery with complicating diagnosis | 372 |
| (4) | vaginal delivery without complicating diagnosis or operating room procedures | 373 |
| (5) | extreme immaturity | 386 |
| (6) | prematurity without major problems | 388 |
| (7) | full term neonates with other problems | 390 |
| (8) | normal newborns | 391 |
| (9) | neonates, died on birth date | 385 |
| (10) | acute adjustment reaction and psychosocial dysfunction | 425 |
| (11) | psychosis | 430 |
| (12) | childhood mental disorders | 431 |
| (13) | appendectomy | 164-167 |

**15.11 Admissions with length of stay exceeding 365 days.** Effective January 29, 2002, the following payment is in addition to the rate per admission under Section 10.01 and the rate per day outlier under Section 10.02 for inpatient hospital services provided beyond 365 days:

Payment = [(Hospital operating cost-to-charge ratio determined in Section 4.01, item D, subitem (4) for all admissions, including General Assistance Medicare Care, a State-funded program) multiplied by (charges for those inpatient hospital services beyond 365 days) multiplied by (disproportionate population adjustment) and multiplied by (the small, rural hospital adjustment) multiplied by (the hospital payment adjustment)]

The payment is not applicable to rate per day payments under Section 10.04.

**Section 15.12 Reduction.** For admissions on or after July 1, 2002, except those paid under Section 15.07, the total payment, before third-party liability and spenddown, is reduced by .5 percent.